WASHINGTON STATE'S HEALTH HOME FACT SHEET
October 1, 2012

1. Why is the state planning to implement Health Home services?

No one enjoys going to the emergency room or being in a hospital. When people have multiple chronic health conditions, getting the care they need can be as challenging as assembling a jigsaw puzzle in the dark. This is especially true when people also have needs for mental health and chemical dependency treatment or require assistance with daily tasks such as taking medication, bathing, transportation, or work. They may have several doctors and care providers that each provide part of the help they need, but they may not communicate with one another about the care needs of the individual being served. We know that when the pieces of an individual's healthcare puzzle fit together they do better and their care costs less.

We want Washingtonians with complex care needs to have the ability and supports to better manage their own health care, to get right services at the right time and place, and to improve their health and quality of life. Based on experience here in Washington and in other states, we know how to make that happen.

2. Who is eligible to receive Health Home services?

Health Home services will be available to individuals with chronic illnesses and who are enrolled in Medicaid or both Medicare and Medicaid. Individuals must also be at significant risk for health problems that can lead to unnecessary use of hospitals, emergency rooms, and other expensive institutional settings such as psychiatric hospitals and nursing homes.

Washington uses a predictive risk modeling system called PRISM to identify individuals who are at significant risk.

3. What kind of supports will be provided to individuals receiving Health Home services?

Individuals receiving Health Home services will be assigned a Health Home coordinator who will partner with beneficiaries, their families, doctors, and other agencies providing services to ensure coordination across these systems of care. In addition, the health home coordinator will make in-person visits and be available by telephone to help the individual, their families, and service providers to:

- Conduct screenings to identify health risks and referral needs;
- Set goals that will improve beneficiaries' health and service access;
- Improve management of health conditions through education and coaching;

- Make changes to improve beneficiaries' ability to function in their home and community and their self-care abilities;
- Slow the progression of disease and disability;
- Access the right care, at the right time and place;
- Successfully transition from hospital to other care settings and get necessary follow-up care;
- Reduce avoidable health care costs; and
- Make health care decisions during evenings or weekends when the Health Home coordinator is not available.

4. Who provides Health Home services?

Health Home services are provided by a Health Home coordinator who will often work at some place the individual already has a relationship with, such as their doctor's office, community mental health agency, tribal clinic, area agency on aging, or similar community based provider.

The Health Home coordinator will be part of a larger network of services that can be called on to help meet an individual's need for medical, mental health, chemical dependency, long term services, and supports.

5. When will Health Home services be available?

Health Home services will be phased-in geographically between April and November 2013. Individuals eligible for Health Home services will be automatically enrolled in a Health Home and will then be contacted to confirm whether they want to receive health home services. For more information, please see our Health Home website: http://www.hca.wa.gov/health_homes.html